

**FY 2008  
PATH FORMULA GRANT APPLICATION  
MONTANA**

**PROGRAM NARRATIVE**

**A. EXECUTIVE SUMMARY**

<b>Program</b>	<b>Service Area</b>	<b>Federal Funds</b>	<b>Estimated Served</b>	<b>Services Supported</b>
South Central MHC	Billings	\$142,449	725	Outreach/Identification Screening/Diagnostic Case management Referral to appropriate services Supportive/Supervisory services Eligible housing services
Western Montana MHC	Missoula	\$50,924.25	250	Outreach/Identification Screening/Diagnostic Case management Referral to appropriate services Supportive/Supervisory services Eligible housing services
Western Montana MHC	Butte	\$22,657.50	75	Outreach/Identification Screening/Diagnostic Case management Referral to appropriate services Supportive/Supervisory services Eligible housing services
Western Montana MHC	Bozeman	\$21,352.50	50	Outreach/Identification Screening/Diagnostic Case management Referral to appropriate services Supportive/Supervisory services Eligible housing services
Western Montana MHC	Kalispell	\$22,657.50	75	Outreach/Identification Screening/Diagnostic Case management Referral to appropriate services Supportive/Supervisory services Eligible housing services
Center for Mental	Great Falls	\$22,657.50	50	Outreach/Identification

Health				Screening/Diagnostic Case management Referral to appropriate services Supportive/Supervisory services Eligible housing services
<b>Total</b>		<b>\$282,698.25</b>	<b>1,250</b>	

The state is withholding a total of \$5,302 for training and quarterly meetings. The PATH providers are responsible for each of their contracts which are different from the previous years. In the past, Western Montana Mental Health Center was responsible for the contract compliance and reporting for Missoula, Butte and Kalispell. Each program has a separate contract with the state with Bozeman as a new provider. In addition, each of the PATH providers are now required to submit their data using the Homeless Management Information System (HMIS).

## A. STATE LEVEL INFORMATION

### 1. Definitions:

a. **Homeless:** A homeless individual means, an individual who lacks housing (without regard to whether the individual is a member of a family), including an individual whose primary residence during the night is a supervised facility that provides temporary living accommodations and an individual who is a resident in transitional housing.

b. **Imminent Risk of Becoming Homeless:** A person is considered to be at imminent risk of becoming homeless if he/she may be evicted, living in temporary or transitional housing that carries a time limit or is being discharged from a health or criminal justice facility without a place to live.

c. **Severe Mental Illness:** The Department has defined an adult with a severe and disabling mental illness as a person who is 18 years old or older that the person:

(a) has been hospitalized at least 30 consecutive days because of a mental disorder at Montana state hospital (Warm Springs campus) at least once;

(b) has a DSM-IV diagnosis of

(i) schizophrenic disorder (295);

(ii) other psychotic disorder (295.40, 295.70, 297.1, 297.3, 298.9, 293.81, 293.82);

(iii) mood disorder (296.2x, 296.3x, 296.40, 296.4x, 296.5x, 296.6x, 296.7, 296.80, 296.89, 296.90, 301.13, 293.83);

(iv) amnestic disorder (294.0, 294.8);

(v) disorder due to a general medical condition (310.1); or

(vi) pervasive developmental disorder not otherwise specified (299.80) when not accompanied by mental retardation;

(vii) obsessive compulsive disorder (300.3)

(c) has a DSM-IV diagnosis with a severity specifier of moderate or severe of personality disorder (301.00, 301.20, 301.22, 301.4, 301.50, 301.6, 301.81, 301.82, 301.83, or 301.90) which causes the person to be unable to work competitively on

a full-time basis or to be unable to maintain a residence without assistance and support by family or a public agency for a period of at least 6 months (or for an obviously predictable period over 6 months); and

(d) has ongoing functioning difficulties because of the mental illness for a period of at least 6 months (or for an obviously predictable period over 6 months), as indicated by one of the following:

- (i) health care professional has determined that medication is necessary to control the symptoms of mental illness;
- (ii) the person is unemployed or does not work in a full-time competitive situation because of mental illness;
- (iii) the person receives SSI or SSDI payments due to mental illness; or
- (iv) the person maintains or could maintain a living arrangement only with the ongoing supervision and assistance of family or a public agency.

**d. Co-occurring Serious Mental Illness and Substance Abuse:** A person with a co-occurring disorder (mental illness/substance abuse) is anyone who has a severe mental illness (as defined above) and who has an identified pattern of abuse of, or dependence on, alcohol or other drugs. The Addictive and Mental Disorders Division has focused on co-occurring disorders for over five years.

## 2. Estimated Need by Geographic Area:

The Montana Homeless Survey for 2008 was conducted in January 31, 2008. The Montana Continuum of Care Coalition, Department of Public Health and Human Services, and the Human Resource Development Councils do the survey annually. The results of the survey have not been distributed. Below are the 2007 Montana Homeless Survey results.

2007 Homeless Survey (Montana Continuum of Care Coalition) by Local Provider<sup>1</sup>

Local Provider	Population	Single Persons	Hholds with Families	Total	% of total
Billings (South Central MHC)	89,847	320	151	471	22
Great Falls (Center for MH)	56,690	144	100	244	11
Missoula (Western MT MHC)	57,053	364	198	562	26
Kalispell (Western MT MHC)	14,223	201	107	308	14
Bozeman (Western MT MHC)	27,509	74	17	91	5
Butte (Western MT MHC)	33,892	71	16	87	4
Remaining Districts	622,981	305	149	454	21
TOTAL	902,195	1479	738	2217	100

<sup>1</sup>

### *Coordination with Montana Council on Homelessness*

The Montana Council on Homelessness (MTCoH) was originally created by Executive Order by Governor Judy Martz in 2004, and continued by Governor Brian Schweitzer in December 2006. Members are appointed by the Governor, and serve 2-year terms. The mission of the MTCoH is “*To develop and implement strategies to prevent and reduce homelessness in Montana overall and to end chronic homelessness by 2014.*” Homelessness rises from and is sustained by three basic factors: personal vulnerabilities; lack of affordable housing; and social policy. The newly appointed Council has been charged with reviewing, editing and approving the draft 10-year plan to address homelessness created by the initial council, and to begin implementing the plan. Numerous strategies have already been put into place in support of the draft plan, including: releasing reports on the state of homelessness in Montana; creating a website ([www.MTCoH.org](http://www.MTCoH.org)); initiating a listserv that receives periodic electronic newsletters; certifying three trainers in the SOAR (SSI/SSDI Outreach, Access and Recovery) process; providing SOAR training to nearly 200 case managers to date; hosting two VISTA volunteers; initiating and/or supporting access fairs for the homeless in three cities; holding memorials for the homeless persons who have died for the past two years; and engaging in numerous opportunities in venues that include television, radio and newspaper to educate the general public about the issue of homelessness in Montana. The MTCoH Coordinator has been named to the National Coalition of the Homeless Board of Directors, and is part of the committee addressing rural social policy for the homeless. The MTCoH serves as Montana’s planning body for formulating and affecting change in the policies and practices that play a role in homelessness, the MHSB and PATH program have been actively involved in the Council’s activities since inception and are an integral partner and resource in these efforts. The state PATH contact is an active member of the Governor’s Council on Homelessness

### *SSI/SSDI Outreach Access and Recovery (SOAR)*

Montana was selected to be one of fourteen states and/or cities for the SOAR project. (SOAR is the acronym for SSI/SSDI Outreach, Access and Recovery.) This has proven to be a highly effective training for case managers who are working with persons who are homeless and have a mental illness. This training has been offered to all case managers and supervisors in mental health and substance abuse agencies and Health Care for the Homeless staff. A total of five trainings have been offered in Great Falls, Billings, Helena and Butte for over a hundred thirty persons trained. The Helena training was offered at the Law Enforcement Academy for discharge planners from Yellowstone (Billings) County Detention Center, Montana Women’s Prison, and pre-release case managers from Butte, Montana State Prison discharge planners, Helena.

The project will be collecting and reporting on outcome data which will assess the effectiveness of Montana’s plan to increase access to disability benefits. Through the SOAR project twenty persons who were homeless qualified for SSI since January 2006.

The PATH annual report for FY 2006 was provided by Western Montana Mental Health Center in Butte, Kalispell, and Missoula; Center for Mental Health Center; and South Central Mental Health Center. The total number of persons served in FY 2006

was 1,363. Of this number 1,097 were enrolled in the PATH programs. All enrolled PATH clients received outreach and case management services.

Demographics of the enrolled PATH clients:

- Age – 26% were 18-34 years; 49% 35-49 years; and 25% 50-64 years.
- Gender – 71% were male and 29% were female.
- Race – 85% Caucasian; 11% Native American; 3% Hispanic; and 2% Black.
- Principal Diagnosis – 36% with Schizophrenia; 25% Affective Disorder; 9% personality disorder; 3% other psychotic disorder; and 27% unknown.
- Co-Occurring Substance Abuse Disorders – 40%
- Veteran Status – 7%
- Housing Status – 15% outdoors; 28% short term shelter; 5% long term shelter; 26% own apartment, dwelling; 5% hotel/SRO; 4% jail; 11% institutions; and 6% other.
- Length of Time Outdoors/short term shelter – 88 persons less than 2 days; 275 2-30 days; 29 31-90 days; 29 91-1 year; and 22 more than one year.

### **3. PATH Site Selection Process:**

PATH funds were competitively bid in the fall of 2007. South Central Mental Health Center providing PATH services in Billings received the first contract for PATH services with the remaining funds competitively bid. The second round of applications resulted in funding for the Butte, Missoula, Kalispell, Bozeman and Great Falls programs. The programs agreed to actively participate in their community continuum of care and use the Homeless Management Information System (HMIS) for data reporting. The RFP is in Appendix A.

In an effort to be sure that homeless veterans are given special consideration, provider organizations are required by contract to carry out and document systematic outreach contacts with appropriate veteran's organizations. This outreach covers Veterans Affairs field offices; the two Vet Centers and the two Veterans Administration hospitals located in the State and are in addition to other outreach efforts that would normally be directed to all homeless individuals who have a severe disabling mental illness. The community mental health centers have contracts with Veteran's Affairs to provide services to those veterans who have a mental illness. In addition, Billings, Missoula, and Great Falls participate in the annual veteran "stand downs".

### **4. Coordination with State Plan:**

The PATH formula grant program is fully consistent and integrated with services provided under Montana's State Mental Health Plan. *Outreach and Engagement* and *Referral and Linkage* are components of Case Management, which has been identified through the planning process as a key service need within Montana's public mental health system. The PATH programs support criteria four, the outreach and linkages, of the mental health block grant. PATH funded services provide the outreach related activity to bring individuals who are homeless and have a serious mental illness into mainstream services.

The PATH program is a key component in the State Plan for Comprehensive Community Mental Health Services. The program is viewed, as the outreach

necessary for this population to access the mainstream public mental health system. This population has also been identified in the Housing Coalition and the Mental Health Olmstead Plan as a priority population to access services.

Community mental health centers utilize shelter plus care vouchers that allow persons with mental illness to access housing in addition to the services available in the community. The communities of Billings, Missoula, Helena, and Butte have access to these vouchers through the public housing authorities. In addition, the mental health centers in Missoula and Helena have their own shelter plus care vouchers. A total of 170 shelter plus care vouchers are available with an additional 131 vouchers were requested in 2007.

The Department of Commerce, Housing Division has received twelve shelter plus care vouchers. These vouchers are available directly to PATH programs to manage. This is a pilot project is developing a collaborative relationship between the Department and the Department of Commerce. Presently, five persons are placed using the shelter plus care vouchers. They are in Bozeman, Kalispell, Great Falls, Butte and Billings. Kalispell, Bozeman, and Great Falls have never had access to shelter plus care vouchers.

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#### **5. Additional Funds Available:**

The mental health and substance abuse block grants are not allocated for serving people who are homeless and have a serious mental illness. There is additional state funds used to provide services to the population, but they are targeted to low-income persons with serious mental illness, not specifically to persons who are homeless. Montana allocates \$100,000 in general funds for PATH.

#### **6. Description of Programmatic and Financial Oversight:**

Oversight of PATH fund utilization occurs through ongoing analysis and summary of data and site visit evaluations. Site visits are conducted jointly by the Quality Assurance Division and the Mental Disabilities Board of Visitors, and are designed to address all services purchased by the State, including PATH funded services. Site visits to PATH providers are scheduled annually. There are no written protocols specific to PATH services. Record review, data analysis, and interviews with staff, consumers, and representatives of various referral and service agencies are employed in evaluations. It is anticipated that the State Contact will be providing more oversight with the PATH programs.

The PATH providers provide quarterly programmatic and financial reports. The State Contact meets with the PATH providers at least annually to discuss problems in the field and provide support to each other. This will be done on a more regular basis as the PATH providers have expressed feelings of isolation and frustration. The decrease in availability of state funded services has impacted the PATH providers significantly.

#### **7. Training for Local Providers**

AMDD has set aside \$5, 302 in FY 2008 for training. These funds are used to provide quarterly meetings with training included and conferences that would benefit the local providers. In the past, the Billings PATH program went to the annual conference on homelessness. AMDD anticipates that local providers will have an opportunity to attend the conference on homelessness in Arizona.

**8. Source of Matching non-Federal Contributions:**

The only revenues used to support services specifically targeted to persons who are homeless with serious mental illness are the general funds used as a match for PATH.

**9. Provision of Public Notice:**

PATH services are discussed at the Mental Health Oversight and Advisory Council, Council on Homelessness, and the State Continuum of Care. The PATH application is made available on the web.



## **Section C: Local Provider Intended Use Plans**

### **SOUTH CENTRAL MONTANA COMMUNITY MENTAL HEALTH CENTER BILLINGS PATH INTENDED USE PLAN FISCAL YEAR 2008**

**Organization**                      South Central Montana Community Mental Health Center (MHC)

1245 N. 29<sup>th</sup> St.  
P.O. Box 219  
Billings, MT 59103-0219  
Phone: (406) 252-5658  
FAX: (406) 252-4641 or (406)238-3617  
Email: [www.scmrmhc.org](http://www.scmrmhc.org)  
Contact Person Gwynn Pederson, LCPC  
Case Management Clinical Coordinator  
Region Served Region III, which includes Billings, Montana

1. The South Central Montana Community Mental Health Center serves an eleven county region in South Central Montana. It is a not-for-profit agency that for over 30 years has been providing a broad array of mental health treatment options to the communities that are located within the region. The Center's main facility is located in Billings. The Center has an open caseload of about 3400 clients at any given time who are seen at the main facility, Journey Recovery, in any of the Center's many different community-based programs located throughout Billings or one of the other seven satellite offices. The MHC has various contracts with local companies for employee assistance. We also contract with the Montana Department of Corrections to provide mental health services to the Women's Prison located in Billings. In addition, we are currently providing psychiatric services, therapy and case management to the veteran population. The MHC Veteran's Administration Mental Health Intensive Community Case Management program extends throughout the state. In Billings, the MHC provides individual and group therapy, chemical dependency treatment and emergency on-call services through our Outpatient Department. The Center's Medical Department provides psychiatric evaluations and medication management. In the Community Support Services Department, alternatives to traditional treatments are available, i.e., residential services, structured day treatment, drop-in services in a semi-structured environment specifically targeting the homeless mentally ill, vocational services, outreach and engagement services to the homeless mentally ill, community-based psychosocial rehabilitation services, Program for Assertive Community Treatment (PACT), and case management services. The MHC is able to offer differing levels of service in our satellite offices. The type of services available depends on the level of need in the community.

2. The MHC receives \$142,449 in PATH federal funds to be used in Billings for fiscal year 2008. The MHC will also receive an additional \$47,483 in state funding. Find attached a budget detailing how these monies will be spent.

3.

a. The MHC PATH program expects to have contact with approximately 725 individuals who are homeless FY 2008 and is estimated that at least 220 of these contacts will be opened as a PATH client and engaged in services. One hundred sixty-five of these open PATH clients are expected to be literally homeless. It is estimated that 50 persons who are at-risk of being homeless will receive some type of PATH funded service.

b. Specific services to be provided in Billings are as follows:

- (1) outreach and identification services;
- (2) screening and diagnostic treatment services;

- (3) habilitation and rehabilitation services;
- (4) alcohol or drug treatment services;
- (5) staff training, including the training of individuals who work in shelters, mental health clinics, substance abuse programs, and other sites where homeless individuals require services;
- (6) case management services;
- (7) supportive and supervisory services in residential settings;
- (8) referrals for primary health services, job training, education services, and relevant housing services; matching eligible homeless individuals with appropriate housing situations;
- (9) housing services including:
  - planning of housing;
  - technical assistance in applying for housing assistance;
  - improving the coordination of housing services;
  - security deposits;
  - costs associated with matching eligible homeless individuals with appropriate housing situations;
  - One-time rental payments to prevent eviction; program director.

c. Outreach and Engagement: The MHC will provide outreach and engagement to the targeted population through concentrated efforts to locate and engage them. The MHC PATH Outreach Team is housed at the MHC Hub Drop-In Center for the Homeless which is strategically located in the downtown area of Billings. The Hub is easily accessed by the targeted population residing at the Montana Men's Rescue Mission, the MRM Women and Family Shelter and those who live on the streets and other places not normally used for human shelter. At the HUB, PATH Liaisons are available on Monday through Friday from 8:00 am to 5:00 pm. PATH Liaisons also provide outreach and engagement services on four days each week at the Community Crisis Center (CCC). The Crisis Center is a mental health pilot program that provides 24 hour/day, every day to individuals who are experiencing a mental health crisis. It is a walk-in facility that is available to anyone in crisis including individuals who are intoxicated. The CCC operates in partnership with the Mental Health Center, the Billings Clinic, St. Vincent Healthcare and the Yellowstone City-County Department. The PATH Liaison is available to offer assistance to those CCC clients who are homeless or at serious risk of homelessness.

PATH Liaisons are out in the community working to identify and engage homeless mentally ill individuals. They have a schedule of regular visits on-site and by phone with over 140 groups or agencies that provide services to the homeless population. Outreach sites include, but are not limited to:

Deering Clinic  
 Billings Clinic  
 Montana State Hospital  
 Tumbleweed  
 District VII HRDC

Health Care for the Homeless Clinics  
 St. Vincent's Hospital  
 Montana Rescue Mission  
 Gateway House Battered Spouse Shelter (YWCA)  
 St. Vincent de Paul Society

Adult Protective Services  
Family Services, Inc.

Probation and Parole  
Friendship House

Montana Rescue Mission  
Billings Police Dept.  
United Way  
NAMI  
Local Churches  
Migrant Council  
(YWCA)  
Streets & Parks

Homeless Camps  
River Areas

Bargain Center  
Yellowstone County Sheriff's Department.  
Vet Center  
CBDG Program, City of Billings  
Yellowstone City-County Detention Facility  
Gateway House Battered Spouse Shelter

Other public locations, i.e., Stairwells,  
Entryways  
Billings Rims (Caves)  
Community Crisis Center

When working on outreach to these and other sites, PATH Liaisons not only seek prospective clients but also provide information about serious mental illness and the community mental health services that are available to assist chronically mentally ill persons in addressing the symptoms they experience.

PATH Short Term Case Management Services: After opening someone as a PATH client, PATH Liaisons will provide support and assistance through short term case management. These case management services will include assessment of needs, planning for meeting the identified needs, crisis resolution and linkage, advocacy and referral services focused on timely resolution of their challenges. The primary focus of PATH case management is to provide or offer access to a full array of services to the client using the Mental Health Center's services or appropriate ones in the community. Finding housing and funding are prioritized as is access to mental and physical health programs. PATH case management provides support to the client until they are assigned to a regular MHC case manager. PATH contacts are opened on their third visit with an eligible consumer. All efforts are made to move PATH clients into regular mental health case management in an expedient manner through the Center case management referral process.

Screening and Diagnostic Treatment Services: PATH clients are assisted in applying for mental health services and then are scheduled for an evaluation by a MHC clinician. If the individual needs assistance to get to and/or from the scheduled evaluation the PATH Liaison will offer transportation through the Center's Community-Based Psychosocial Rehabilitation Services Program. The clinical evaluation serves as a tool to access MHSP coverage and other entitlements such as medication management, therapy, Social Security benefits, food stamps and an array of other important supports that are available to individuals who are SDMI. Additionally, the PATH program will provide limited financial assistance to assist a PATH client to access psychiatric treatment. Therefore, PATH clients will be able to receive initial outpatient medical service to facilitate stabilization in the community. The Yellowstone City-County Health Department Health Care for the Homeless Clinic is available two afternoons each week to any homeless

person who comes in. Their services include physical and mental health treatment. The Clinic offers assistance with medications for individuals who have no way to pay for them. These medications include psychotropic medications. If the client has MHSP to cover medications, the Clinic will assist with the co-pay. As previously stated, the MHC Journey Recovery program is available to those who are dealing with chemical abuse issues as well as those who have co-occurring disorders. The MHC agrees that no PATH funds will be used to pay for inpatient services.

Habilitation and Rehabilitation Services: At the MHC, recovery is recognized as a true possibility for individuals who are seriously mentally ill. PATH Liaisons recognize the need of the homeless SDMI individual to regain a level of function that brings a sense of competency to them and offers restoration of fundamental community membership. Many opportunities for assistance with rehabilitation exist in the Billings community. Access to a network of supports and services is available to PATH participants through various agencies in the community, i.e., Voc/Rehab Services, COR Enterprises, Job Connection, the Lincoln Center, MSU-B College of Technology and Labor Ready to name a few. The MHC provides Community-Based Psychosocial Rehabilitation Services (CBPRS) that improve the participants' ability to regain or develop activity of daily living skills and to access community providers and resources. CBPRS also focuses on teaching PATH participants how to develop social skills, interests and leisure time activities as they learn to cope with their illness. Rainbow House and the Center's residential services offer daily living skills and socialization, too. Taking control of their lives through effective treatment, case management and rehabilitation services offers PATH participants hope for recovery.

Community Mental Health Services: Providing access to community mental health services is primary to participants' success on the road to recovery. The PATH Team works advocates for their clients by utilizing linkage and referral activities to establish relationships with essential mental health treatment resources. In the Billings community multiple treatment options exist. Billings Clinic, Deering Clinic, Yellowstone City-County Health Department's Health Care for the Homeless, Indian Health Services, Veteran's Psychiatric Services, St. Vincent Healthcare, Community Crisis Center, Behavioral Health groups and private providers offer choices to PATH participants. The MHC provides a wide variety of treatment options whose goals are to provide excellent services. Targeted Case Management continues the same type of case management as PATH, but on a continuing basis. The homeless person with SDMI may become eligible for assignment to a targeted case manager who will make coordination and continuity of care readily available. PATH Liaisons refer participants to any of these services as appropriate. As stated previously, the PATH program will provide limited financial support for access to psychiatric treatment. PATH clients will be able to receive initial outpatient medical service to facilitate stabilization in the community.

Training for PATH Staff and Community Providers: Applicants for PATH positions must understand the plight of the homeless and possess an extensive knowledge of community resources and services to be considered for hiring. Once selected as PATH

Liaisons, program employees will receive the program description and training information from the PATH Project Director. Regular supervision and trainings addressing diagnosis, dual diagnosis, symptom monitoring, treatment planning and crisis management techniques will be provided to PATH staff. The PATH Team Lead will provide immediate and on-going support and supervision. The MHC will continue to offer additional clinical training to all personnel including PATH Liaisons. PATH Liaisons will be offered a continuum of education applicable to this population through current research and updates on successful interventions and treatment. The MHC recognizes the need for cultural awareness, education and inclusion. Opportunities for diversity and awareness training are seen as successful, applicable vehicles to services that are culturally enriched. The current PATH Team is ethnically diverse, thus enriching the PATH Program. PATH staff and the Project Director will continue to be available to present pertinent information about mental illness and the PATH program to local shelters, universities, interested organizations and particularly, supportive agencies who serve this population.

Case Management, Residential Services and Other Center Services: The MHC offers case management services for adults with severe disabling mental illnesses. The Center has 36.5 FTEs providing case management services in Billings through the PACT Program and Targeted Case Management. PATH clients will continue to be referred to the appropriate case management services within the community.

d. PATH eligible clients come to the PATH program with multiple needs ranging from housing to mental health services, from daily living skills to medication management; from financial to social skills; from educational to physical health; from substance abuse to legal assistance; from employment to disability benefits; from food to hygiene articles; from bathing to laundry; from transportation to warm clean clothing; from establishing communication with family to comprehensive advocacy. One gap the Center has identified is the lack of sufficient staff available within the community. Another gap in Billings is the limited number of adequate, affordable housing units in safe neighborhoods. The NIMBY attitude and stigma are impediments that interfere with access to needed services. Lack of financial support is a gap that often limits the homeless individual's ability to move forward to the next level of housing. Homelessness may lead to a poor credit history, lack of a local mailing address, poor rental history (or no rental history) and in addition, the existence of a criminal background and/or current criminal activity limits the homeless individual's access to treatment and housing.

e. PATH participants who have need of treatment for chemical dependency issues are referred to appropriate services in the community. The MHC itself offers comprehensive treatment through its Journey Recovery Program in the Outpatient Department. Treatment is available in a variety of forms such as individual outpatient or through a treatment group for individuals with co-occurring disorders. The MHC continues to work to expand and develop an integrated approach to treating dually diagnosed clients and offers medication management appropriate for them. PATH Liaisons collaborate with Yellowstone City-County Health Department's Health Care for

the Homeless Clinic's licensed addiction counselor. They may also refer to other community chemical treatment programs and inpatient treatment facilities for American Indians and Non-Native individuals. All PATH Liaisons will be offered training in dual diagnosis to equip them with skills necessary to locate the most appropriate services to each individual with co-occurring disorders in this population. They will work closely with the Center's Chemical Dependency Department to advocate for the identified client and to ensure access to treatment. Although PATH funds are not used to provide co-occurring training the MHC continues to work to expand and develop our clinical and

4. In Montana, the HUD Continuum of Care (CoC) is managed at the state level. The MHC has an established membership at both the local and state level in both HUD Continuum of Care groups. The PATH Project Director serves as the MHC and PATH representative at both of these groups. When the Project Director is unable to attend meetings of either group, the PATH Team Lead will serve as an alternate. The PATH program coordinates the annual Point in Time Survey for the Billings community.

It is anticipated that the MHC and the PATH program will apply for a HUD Safe Haven Permanent Housing Grant in the 2008 application round. This program would increase the alternative housing situations available to the homeless SDMI population.

case management staff's knowledge of dual diagnosis. The Center offers an integrated approach to treating dually diagnosed clients. The MHC will continue to use PATH funds to provide limited evaluation and medication management to PATH clientele. As PATH Liaisons continue collaboration with Yellowstone City-County Health Department's Health Care for the Homeless, they will also refer to other community chemical treatment programs, local inpatient treatment facilities and those specifically identified for American Indians and non-native individuals.

f. In Billings, housing availability is limited and it is often difficult to find safe and affordable housing for clients. Available rentals range from efficiency to multi-bedroom houses/multi-plexes with monthly rent ranging from \$200.00 to as much as \$600.00. PATH Liaisons make application for housing assistance through the Section 8 programs, assisted housing units, mod-rehab rentals and the Yellowstone County general relief assistance program. The PATH program has direct access to Shelter Plus Care vouchers through the Department of Commerce. Additionally, the MHC has been an active partner with the Housing Authority of Billings in obtaining funding for this population in Billings through a federally funded Shelter Plus Care grant. The Clinical Coordinator of Case Management services at the MHC screens all applications for the program as well as tracks and documents all matching services needed to maintain the grant match. Currently, the Center is working on an application for a Section 811 HUD grant to develop additional housing in the community.

Locally, the community of Billings Continuum of Care has no ability to seek funding and has not been formally established. As part of the CoC process, the Center assists with surveys and community needs assessments. The Yellowstone County Project for the Homeless Board is a non-profit entity made up of local agency representatives and interested community members-at-large whose focus is addressing the issue of homelessness and the problems that come with it.

The Center has been part of this group for over 10 years. The MHC has been an active partner with the Housing Authority of Billings in obtaining funding for homeless mentally ill individuals in Billings through a Shelter Plus Care grant. Individual PATH Liaisons and other MHC Case Managers provide community support through assistance with activities of daily living, crisis resolution, linkage, referral and advocacy to participants to maximize the opportunity for the ongoing resolution of homelessness. The Clinical Coordinator of case management services at the MHC screens all applications for the program as well as tracks and documents all matching services needed to maintain the grant. A file containing required documentation of matching services is maintained at the MHC.

5. The Annual Point-In-Time (PIT) survey conducted January, identified 320 homeless individuals living on the streets, in doorways and alleys, under bridges, in the rescue missions, homeless camps and other places where the homeless congregate in or around Billings. Of those 320 persons, those with serious disabling mental illness (SDMI) numbered 213 (PIT Survey quoted in the Department's Application for Federal Assistance SF-424). When reviewing this number, one must take into consideration that this is a survey completed on one specific date of the year. This number does not reflect at least 30% of the recognized homeless population because they do not want to be identified. Additionally, over the course of a year the total number of homeless individuals in Billings is much higher than the survey would indicate because of the transient nature of this population.

Bob Buzzas, Coordinator of the MT Continuum of Care reports in his June 6, 2007, letter to the Department, “Using an average of three years of survey data, the Billings area accounts for almost one-third (31%) of the state’s entire homeless population...” When analyzing the 2007 PIT Survey information using a HUD formula for determining unmet need, 57 individuals were in need of some type of housing and supportive services. Forty percent of the homeless individuals identified through self-report as mentally ill and 33% of those self-reporting substance abuse were in the Billings area (Bob Buzzas). “While I am in no position to judge the best allocation of PATH resources statewide, I can say that the homeless situation in [the] community of Billings is very dire.” (Bob Buzzas) PATH Quarterly reports for the past five years led the PATH Team to believe that this estimate may be an underestimation of homeless individuals who experience symptoms of serious disabling mental illnesses. Continued outreach into the community is expected to identify up to 725 homeless SDMI individuals. Of those, at least 220 contacts will engage in PATH services.

The MHC believes that all individuals have the right to be treated with dignity and respect regardless of age, gender and/or racial/ethnic differences. Inter-team clinical staffing and weekly meetings with PATH Liaisons and other case managers offer opportunity to address issues that might be reflective of these differences. The Center sends PATH personnel to cultural competency training when it is reasonable to do so. Each MHC department assumes Responsibility for maintaining acceptable levels of understanding of cultural/age/gender differences. The Center also offers access to translators when necessary to assist those clients who are more comfortable with a language other than English. The MHC serves a diverse population of which the significant majority is Caucasian. Although located near the Crow and Cheyenne Indian Reservations, the number of Native American clients served through the PATH program remains small. The PATH population served in Yellowstone County also may include Hispanic and African American clients. The MHC employs a large staff that includes individuals whose ages range from early twenties to retirement age. Our employees are racially/ethnically diverse, representing a cross-section of the general population of Yellowstone County. Also important to note is that the MHC is an equal opportunity employer and our hiring practices fall within the standards and regulations for such an employer. The Center has provided and will continue to provide training in cultural competence. Most recently, PATH Liaisons had the opportunity to attend an educational presentation that was related to the social psychology of the American Indian Tribes.

6. The MHC will offer consumers and family members, community representative and other interested parties the opportunity to serve on a PATH Program Advisory Board. Their input is seen as very important as we continue to develop and expand the support of PATH to the SDMI homeless population. Board members would be asked to participate in quarterly meetings to be held at the HUB where they would bring issues or concerns, suggestions and identify gaps in our community. They would also be asked to offer advice to the PATH program to ensure that the needs they see for this population are attended to. Participation of Board members in the annual Point-in-Time Survey would be invaluable as the community assesses the homeless population numbers, locations and needs. The knowledge and understanding this experience will provide would serve as valuable input for the PATH program Advisory Board.



## **Budget Narrative**

### **Section A – Mental Health Clinical Employees**

Three outreach workers, one team lead and a 0.1 FTE of a licensed clinical coordinator will comprise the clinical component. The outreach workers and team lead positions are bachelor level. The licensed clinical coordinator position requires a master's degree and the appropriate licensure to provide clinical supervision to the PATH program and team members.

### **Section B – Mental Health Center Support Staff Salaries**

The business and clerical support will be comprised of participation from various members of both the business office and secretarial pool employed at the Mental Health Center.

### **Section C – Contracted Services**

Both the psychiatrist and janitorial services will be contracted in the Billings community. The psychiatric portion will allow for purchasing 20 hours of psychiatric services per year which is calculated at \$200/hour for 20 hours annually. It is estimated that 40 half-time psychiatric encounters will occur during the PATH grant year. Contracting with community psychiatric providers will allow the Center to better meet the needs of PATH clients with complicated medication regimens and complex symptomatology.

### **Other**

Utilities will include electrical, water, and natural gas. Communication consist of a land line phone and four cell phones plus the monthly services charges. Supplies are broken down into the categories of patient activities, office, photocopy, and printing, record keeping and janitorial. The costs are based upon previous year usage.

Staff development consists of attending special training; conferences and team building activities and events.

The housing assistance revolving loan fund will be utilized for assistance with providing housing to the population we are providing services to. Examples of these costs include deposits for utilities and rent; limited emergency shelter; one time only rent payment; medication and medication co-pays. This fund has been made available through the PATH program for over 18 years. This fund will be administered by the Project Director who will monitor and approve or deny requests for fund dollars based on diagnostic criteria, homeless status as well as level and type of need.

Administration expense consists of 4% of the budget. It includes recruitment and advertisement. All position openings are advertised both internally and externally. Advertisement media of local and regional newspapers and television are often used. Advertising for direct program

activities are also included, as well as postage. Legal fees, accounting fees, management, malpractice insurance, data processing, licenses and miscellaneous fees and items are included as administrative expenses.

Miscellaneous expenses include recruitment and advertisement for employees. Legal fees, accounting fees, malpractice insurance, clinical and vehicle licensure and miscellaneous fees and items are included as administrative expenses.

## **Western Montana Mental Health Center Missoula FY 2008**

1. Western Montana Mental Health Center,  
T-9 Fort Missoula,  
Missoula, Mt.  
406-532-8408  
406-543-9316  
[pmeyer@wmmhc.org](mailto:pmeyer@wmmhc.org)

WMMHC provides mental health services to Western Montana. Missoula County Adult Mental Health (MCAMH) provides mental health services to seriously disabled mentally ill adults (SDMI) in Missoula County (population 100,000). These services include Day Treatment, Psychiatric Medication Clinic, Outpatient Therapy and Case Management Services, Crisis Stabilization Services, Emergency Services, PACT, residential services, and mental health services to veterans. PATH services have been provided for 10 years through Adult Case Management Services and serve over 200 persons annually.

Path workers do daily outreach to identify and offer services to homeless persons, spending approximately 2 hours daily at either the Poverello Center, which is a shelter providing both meals and beds to homeless persons and Missoula 3:16, which is primarily a meal site for homeless persons. In this manner, PATH outreach workers are very visible and develop relationships over time with homeless persons who also have mental illness. These workers are often the only contact a vulnerable person with mental illness will allow. These workers establish close referral relationships with the staff in these centers, which encourages referral and the use of PATH workers for consultation. This proposal seeks to continue these essential services as well as develop and enhance services to veterans who may be homeless and mentally ill. This would be accomplished through retaining the services currently offered and hiring an additional outreach worker to specifically develop referral liaisons to veterans and veterans' service organizations.

2. Western Montana Mental Health Center in Missoula will receive \$50,924.25 in federal PATH funds.

3.

a. It is estimated that there are potentially as many as 342 persons who may become PATH eligible during the FY 2008 and are literally homeless. This proposal estimates to reach 250 persons. This is based on past figures regarding service utilization and projects an increase if this proposal is accepted. This would represent 98% literal homelessness. Those at risk for homelessness and potentially eligible could be as high as 720, as the figures cited in 4.2.3 indicate. This data is from the 2007 Montana Survey of the Homeless.

b. The percentage of persons with mental illness or substance abuse disorder and **literally** (by **Outreach** will be provided by three PATH workers who will go daily to homeless shelters to introduce themselves to persons who might benefit from assistance, due to homelessness and mental illness. They will introduce themselves to agencies in the community who provide services to persons who also work with homeless persons and assist these agencies in identifying persons who might be experiencing a mental illness and facilitate referrals. Persons with mental illness who are homeless are generally not medicated and have minimal or no treatment resources. They are generally suspicious of other's intent and have difficulty forming relationships. Both outreach to shelters, agencies and individuals themselves allows an individual to form relationships slowly without pressure. Path workers will also provide **engagement**, which is the process of forming a relationship or offering assistance. It may involve brief social contacts with no agenda. This may be rejected by the individual and require additional contacts. **Short term case management** provided by PATH workers are assisting a person obtains some basic support with any identified need. It could involve contacts with Social Security, landlords, medical providers, crisis services. The process of **linkage and referral** is a case management task that PATH workers provide in assisting a person in making and keeping an appointment with an outside provider. The act of making and keeping appointments can be extremely difficult for someone who is homeless and without support and experiencing symptoms of a mental illness. Path workers provide **advocacy**, which is effort made on a person's behalf to encourage other service providers to assist a person. **Assistance with basic needs** will be provided through the PATH revolving housing fund to assist with security deposits and the case management emergency fund. Outreach, engagement, short term case management, supportive services, referral and linkage to appropriate services, advocacy for obtaining mainstream services, assistance with basic needs, will be the primary services offered through PATH. Consumers will be referred for additional screening and diagnostic treatment services; habilitation and rehabilitation services; community mental health services; and alcohol or drug treatment services; these services will not be directly provided by the PATH staff.

c. Share House, which provides detox to homeless persons and is not PATH, funded serves approximately 125 persons per year. The local system also includes two homeless shelters, transitional housing through the YWCA, local food bank and two meal sites. Poverello, a shelter in Missoula, provides 15,000 shelter days per year and 100,000 meals to homeless persons. Partnership Health Center provides medical and dental care and provides medical care through the Health Care for the Homeless project. There are two shelters serving homeless persons in Missoula. Poverello is the largest homeless shelter in Montana and

provides approximately 15,000 days of shelter, as well as 100,000 meals per year. Additionally there is a second homeless shelter and meal site in Missoula, 3:16

Some of the organizations that do not receive PATH funds, but provide services and housing to eligible clients include: The Poverello Center is a homeless shelter. They provide 15,000 nights of shelter and 100,000 meals to homeless persons. Missoula 3:16 is a mission that provides meals and shelter. The Salvation Army provides emergency assistance to homeless persons. Western Montana Addiction Services provides detox for substance abuse to homeless persons. Office of Public Assistance provides food stamps and financial assistance. Partnership Health Services provides medical and dental care, as well as nursing services. Missoula Housing Authority provides housing assistance. Section 8 Housing provides housing assistance. Missoula Veteran's Center provides case management, counseling and referral. Missoula Indian Center provides counseling and referral. YWCA provides emergency housing to victims of domestic violence.

MCAMH coordinates its services with the agencies identified above by assigning PATH case managers to outreach homeless individuals identified as having mental illness and linking these individuals with necessary and appropriate services. Our PATH case managers are well known in the community, as are the protocols regarding funds available, functions of PATH services, how to access those services and how to make appropriate referrals. They spend a portion of their time each week providing outreach and continuity of care with the above organizations.

d. Missoula is one of the larger cities in Montana. The population of the county is approximately 100,000. Missoula is a University town, with a seasonal increase in housing demand, due to the University of Montana. There are approximately 13,000 students who attend the University of Montana. Due to the influx of these students competition for housing is great and rent costs are escalated. 14.3 % of Missoulians were estimated to live in poverty in 2000, according to Missoula County statistics. 15-17% were uninsured.

Missoula is located off of I-90 and is easily reached by persons traveling East, West, North or South through Montana. It is easily accessed from Spokane. There are two agencies providing homeless shelter and meals and there are services that attract both homeless persons and persons with disabilities to Missoula. There is low-income health care available through Partnership Health Center, as well as dental care. There is an abundance of natural beauty and yet a rural atmosphere that helps persons with mental illness and persons feeling ostracized from society feel safe. Additionally, Missoula has been home to many persons who choose alternative lifestyles and is a fairly tolerant community.

e. PATH workers are trained in the identification of substance use disorders and in the philosophy of co-occurring treatment that emphasizes "No wrong door" and integrated treatment. The staff is knowledgeable about treatment options, including peer support recovery options and resources for detox of persons who are homeless. All efforts to assist persons at all stages of change in their recovery process are made. Family members are included in the process whenever possible.

f. Our PATH specialist coordinates with local landlords and the Missoula Housing Authority to identify housing that would include: apartments, efficiency apartments, shared housing with peers, assisted living and transitional housing opportunities. It primarily involves networking, assisting with security deposits, completing applications.

PATH workers and MCAMH works closely with Missoula Housing Authority and the Human Resource Council to assist persons with mental illness who are homeless in obtaining affordable permanent housing. Additionally, MCAMH has been instrumental in building and sustaining an apartment complex that provides permanent housing to 20 consumers, as well as a rental duplex. In a collaborative effort with Missoula Housing Authority in 1990, seven condominiums in a complex of 36 were reserved for purchase by persons with mental illness. MCAMH has assisted persons in securing rentals through the use of security deposits, using PATH funds; agency emergency funds and Montana State Hospital grant options.

4. Missoula Adult Mental Health Services (MAMHS) is an active participant in the At Risk Housing Coalition (ARHC) and maintains strong relationships with other local providers who work with homeless persons, providing shelter, health care, food and other emergency services. This committee assesses needs, develops resources and responds to those needs in the community. This planning process is involved in the Continuum of Care and Consolidated Plan.

5. A transient woman with serious mental illness who was homeless drowned in the Clark Fork River. There are incidents on a regular basis of a person's symptoms escalating, loosing housing, traveling, and being unable to access services. A person with mental illness living with an elderly mother was unable to pay the mortgage on his home and the property was foreclosed upon, both are now homeless. There are many situations where people on fixed incomes have a brief financial problem that results in homelessness.

The target population would include persons who currently live in the Missoula area and become displaced, resulting in homelessness. Additionally there is a large transient population that is drawn to Missoula partly because services are available. These are primarily persons with Serious Disabling Mental Illness, including Schizophrenia, bipolar disorder, depression, anxiety disorder and personality disorders. People with mental illness are very vulnerable to housing discrimination; are extremely low income, at risk for encounters with law enforcement, which puts these consumers at greater risk for homelessness. Additionally there is a lack of affordable housing, cutbacks in health, mental health and substance abuse treatment services, which increases the risk of homelessness.

Mike Kantor has 15 years experience, providing services to SDMI adults and 8 years working with homeless persons with mental illness through the PATH program. Mike has done outreach with PATH clients, worked on relationship building, done de-escalation of crisis situations and is presently a supervisor of PATH staff. He has 15 years experience providing and/or supervising Case Management services, which is one of the critical PATH tasks. Laura Smrcka has a bachelor degree, 3 years experience with persons with SDMI,

and previous experience working at a homeless shelter. Hal Mathew has a bachelor degree and has been employed as a case manager for 12 years by MCAMH; he has been involved with PATH for 1 year and has additional substance abuse treatment experience.

**Skills and Abilities:** Ability to establish and maintain effective working relationships within the agency, with consumers, with family members, and with personnel from other agencies and professions; to exercise professional judgment in evaluating situations and making decisions; and to communicate effectively orally and in writing. Ability to work effectively with persons who are homeless.

6. PATH staff in the course of doing outreach and coordination solicit feedback from consumers and family members regarding implementation, evaluation and planning of services. This feedback from both prior and current PATH clients will be used to modify PATH service delivery as necessary, appropriate and possible. We will offer consumers the opportunity to complete a written questionnaire on the PATH services they have received.

## Missoula Budget 2008

	Total
<b>I. Personnel</b>	
<b>A. Salaries</b>	
Outreach worker .5 FTE	\$12,840
\$25,680annual salary	
Outreach worker .5 FTE	\$12,840
\$25,680annual salary	
Program coordinator .5 FTE	\$14,840
\$27,680annual salary	
Clinical Supervisor 2 hours per week @ \$50.00/hour	\$5,200
<b>B. Fringe benefits/Health Insurance</b>	
.5 FTE	\$3,500
benefits	
.5 FTE	\$3,500
benefits	
.5 FTE	\$3,500
benefits	
<b>Sub-total</b>	<b>\$56,220</b>
<b>II. Travel</b> (in-state only related to the project)	
200 miles/week @ .485 X 48 weeks	\$4,656
<b>Sub-total</b>	<b>\$4,656</b>
<b>III. Other</b>	
Administrative overhead	\$5783
9.5%	
Housing asst. revolving loan fund	\$1240
<b>Sub-total</b>	<b>\$6,637</b>
<b>Totals</b>	<b>\$67,899</b>

**\$50,924.25 is federal funds and \$16,974.75 is general funds**

## **Western Montana Mental Health Center Butte FY 2008**

1. The WMMHC – Butte office, provides services to seriously disabled mentally ill adults and children with serious emotional disturbances; serving the totality of Silver Bow County which boasts a population of 36,000. The mission of WMMHC has been to assist individuals with mental illness, and chemical dependencies and/or severe emotional challenges to achieve their highest quality of life in relationship of mutual respect, dignity, and empowerment. Services are offered by the center regardless of age, race, sex, color, religion, marital status, sexual orientation or disability.

WMMHC collaborates with community, state and federal entities to insure that special population such as the Veterans and the Native American population are served. The varied array of services that WMMHC-Butte offers shows a commitment to meet the needs of the vulnerable population; adults and children suffering from mental illness.

Proposed services of this proposal will be provided by WMMHC-Butte area. This facility has been doing business since 1997. Prior to that time, Butte offices functioned as a community mental health center under the direction of Montana Health Services, Inc. Specifically, Butte began offering PATH services in 1999. Upon reflecting on the provision of PATH services and operations, WMMHC has serviced and placed between fifty (50) to fifty five (55) PATH consumers in the past three years. It is our belief that we can service more consumers which allows the center to intervene proactively upon those challenges that affect the mentally ill and co-occurring populations. All consumers serviced by WMMHC participate in a treatment plan that assists them with developing permanent housing and as well addresses and endorses the use of center and community services that will help maintain the stability of the consumer with variables such as: housing, food, medication management, case management support and therapies.

Contact: Jodi Daly, LCPC, CMHP  
Southwest Director of Mental Health Services  
Western MT Mental Health Center  
106 West Broadway Street  
Butte, MT 59701  
Phone: 406-723-4033  
Fax: 406-723-7117  
[jdaly@wmmhc.org](mailto:jdaly@wmmhc.org)

2. Western Montana Mental Health Center – Butte will receive \$22,657.50 in federal PATH funds.

3. a. The number of individuals literally homeless, served by PATH in fiscal year 2007, is 15 people; 2006 served 30 people, fiscal year 2005 served 20 people and in 2004 we served 17 people. These numbers are drawn from the quarterly PATH reports completed by our PATH providers the 'literally homeless' are people living outdoors or in short time shelters at the time of first contact with PATH providers.

The Montana Homeless Survey, which is a point in time survey that was taken on January 31, 2007, identified 71 homeless respondents/adults and 87 respondents + families with children in Butte. The number of consumers served in the last fiscal year was 58. Of the 58 consumers served 28 were female and 30 were males. Of this population four were Native Americans, two African Americans, and six veterans. Of the 58 consumers we provided PATH services to 34

suffered from a co-occurring disease of substance abuse, and all 58 received treatment for a mental illness.

It is estimated that there are potentially 100 to 150 homeless persons who will use the PATH service. This is based on past figures, utilization of service, and projects an increase in number to be served if this proposal is accepted, due to a request for additional staffing. This would represent a 98% of 'literal' homelessness. Those at risk for homelessness are high due to the high cost of rentals in the Butte area as well as the occurring problems. We frequently see people applying for PATH due to their inability to pay deposits on utilities and rentals. Without PATH services they would not be able to have adequate housing.

b. The target population for the proposed services will be those at risk of becoming homeless as well as those who are literally homeless, as well as those individuals who are unknown to the center but are in need of assistance. Services that will be offered will include: outreach, engagement, short term case management, supportive services, referrals and linkage to appropriate services, advocacy for obtaining mainstream services, assistance with basic needs including safe and adequate housing, linkage to Indian Alliance Center, Veterans Administration and Social Security, will be the primary services offered by the PATH. Consumers will be referred for additional screening and diagnostic treatment services; habilitation and rehabilitation services; community mental health services; and alcohol or drug treatment services; these services will not be directly provided by PATH staff. However, these referrals will allow for proactive treatment planning and intervention for those who are challenged by mental illness and co-occurring disorders.

Applicants receive services within 48 hours of the initial contact. Services will continue for the consumer through the PATH program until the process of enrollment in traditional services is completed. Our PATH services function within the budget allotted to our area. PATH providers do continue to provide services of coordination, outreach, linkage, and case management when the financial support has been exhausted. PATH consumers are usually engaged in traditional services within ninety days of the initial application for services.

c. WMMHC-Butte has provided PATH services in the community since 1999. Currently a case manager is assigned to outreach homeless persons with mental illness in the community. The PATH funded Case Manager outreaches persons with mental illness in the community on a daily basis. Outreaches can occur at the bus depot, local parks, street corners, Rescue Mission, Salvation Army, hospital, jail and local single room motels. The PATH case manager spends portions of their week providing outreaches and education to the following agencies:

*Salvation Army*-provides fellowship meals, food and gas in emergency situations also clothing a temporary housing

*Butte Rescue Mission*-provides temporary housing clothing and meals

*Human Resource Council*-provides various low income programs including job training, emergency assistance, food, shelter, and more

*Office of Public Assistance*-provides basic assistance needs such as TANF, food stamps, and other public assistance programs

*Public Housing Authority of Butte*-provides low income housing to individuals and families

*Butte Chemical Dependency Services*-provides drug and alcohol counseling

*American Indian Alliance*-provides support and assistance to Native American population

*Department of Family Services*-to provide emergency care for children

*Butte Community Health Center*-provides a full range of family health services and supports Health Care for the Homeless

d. Butte is the closest city to the Montana State Hospital and is often the first contact for patients that are discharging homeless. Butte is centrally located to two main interstates bringing in a large number of the traveling homeless population. Although we have experienced a rise in the cost of living in Butte we are still relatively cheaper to live than other cities in Montana, making housing and the daily cost of living more affordable than other communities.

The primary need of the target population is to obtain adequate, safe, and stable housing as well as to engage the individual in mental health services to remain stable in the community. Many PATH participants will have medical complaints at the time of initial contact and are linked immediately with Health Care for the Homeless to obtain the needed medications and healthcare. This population has often lost their incomes due to their mobile behaviors, or have not stayed in one place long enough to complete the requests for benefits. PATH providers immediately address the need of financial resources along with shelter and food.

e. Integrated co-occurring services differ from traditional treatments services in several ways. One practitioner or team provides substance abuse treatment and mental health treatment in collaboration versus outsourcing those referrals. It has been found that integrated treatment offers the best chance for recovery of consumers as they do not get “lost” in the system, excluded, or confused while going back and forth between programs. WMMHC-Butte recently signed a Memorandum of Agreement with Butte Silver Bow Chemical Dependency (BSBCD) which allows for the collaboration of an LAC to facilitate groups for those with co-occurring disorders through Silver House. This collaboration also involves the training of one of our own case managers who is in the process of obtaining his LAC. BSBCD and WMMHC have been meeting to increase communications and to educate one another on symptoms and issues related to mental illness as well as chemical dependency symptoms and issues. WMMHC also collaborates with Montana Chemical Dependency Center and the American Indian Alliance on shared consumers in need of treatment options. Assessing the best services along with cultural preferences is a standard of providing care and services. It should be noted that WMMHC interfaces with BSBCD, MCDC and the Native American Alliance during community meetings and forums as well as independently when consumer are in need or crisis.

WMMHC-Butte staff is trained to work with consumers with co-occurring disorders and serve consumers in either collaboration with local chemical dependency services or within the operations of the center. For consumers with primary substance abuse issues, treatment referral options are in place for both detox and for outpatient treatment with Butte Chemical Dependency. There will ongoing coordination and linkage with substance abuse treatment providers, including Native American and Veterans programs. Additionally peer support groups such as AA, NA and dual diagnosis groups will be utilized for referral and support. The WMMHC-Butte office recently hired three Peer Support specialists to enhance consumer directed efforts in recovery. In addition WMMHC-Butte has recently contracted with Butte Chemical Dependency office to have a Licensed Addiction Counselor facilitate a weekly Addictions group at the Silver House location. A new Gilder House Crisis Stabilization Center will have the capability of providing social detox at their site. This new program is estimated to open in spring/summer of 2008.

f. WMMHC-staff work to ensure that safe and stable housing is available to consumers. The PATH Specialist coordinates with local landlords and the Public Housing Authority to identify affordable and stable housing to include: apartments, efficiency apartments, shared housing with peers, assisted housing and transitional housing opportunities. The PATH Specialist sits on a local housing task force (Interagency Task Force) which addresses housing concerns in Butte

Silver Bow. WMMHC-Butte in recent years has developed and operationalized its own affordable housing projects to ensure affordable and safe housing to the consumers served. Currently, WMMHC-Butte hosts a group home and an apartment complex. A pro-forma is currently being developed to assess whether another group home would be beneficial.

4. WMMHC-Butte is an active participant in the local housing task force (Continuum of Care for the Homeless) and maintains strong relationships with other local providers who work with the homeless population. Other local providers could be providing shelter, health care, food or emergency services to the homeless. This committee assesses needs, develops resources, and responds to identified needs in the community. The planning process is involved in the Continuum of Care and Consolidated Plan at the State level.

5. The target population for the proposed services will be those at risk of becoming homeless as well as those who are literally homeless, as well as those individuals who are unknown to the center but are in need of assistance. Services that will be offered will include: outreach, engagement, short term case management, supportive services, referrals and linkage to appropriate services, advocacy for obtaining mainstream services, assistance with basic needs including safe and adequate housing, linkage to Indian Alliance Center, Veterans Administration and Social Security, will be the primary services offered by the PATH. Consumers will be referred for additional screening and diagnostic treatment services; habilitation and rehabilitation services; community mental health services; and alcohol or drug treatment services; these services will not be directly provided by PATH staff. However, these referrals will allow for proactive treatment planning and intervention for those who are challenged by mental illness and co-occurring disorders.

There is currently two primary staff providing PATH services to the Butte community. The program supervisor Renee' Rogers has provided PATH services for the two years prior to becoming the supervisor of the PATH program as well as the program lead for all Adult Case Managers in the Butte office. Renee' has supervised the PATH program for the last five years and is dedicated to assisting the homeless. The primary PATH specialist is Dori LeFleur and she has worked in the PATH program for the last four years and has seven years experience as an Adult Case Manager. Chris Weber has been assisting with the PATH program for the last six months as a relief worker and is very interested in working with this population. Chris has one year experience as an Adult Case Manager.

Ms. Rogers has over seven years experience working with the homeless and the last five years as a supervisor for the WMMHC PAATH program. She attend monthly meetings of the Interagency Task Force, APS monthly committee meetings, We Deliver/Help the Homeless Program, Health Care for the Homeless Conferences, and is instrumental in the completion of the annual homeless survey conducted yearly in conjunction with the HRDC. Ms. LeFleur and Mr. Weber are also attending these meetings and continue to deliver lunches to the homeless in Butte, which provides them with the opportunity to meet the homeless and talk with them regarding their need for services and what services they are in need of.

6. PATH staff in the course of doing their work solicits comments from the client base as well as families regarding the services provided. We have recently designed a PATH RECIPIENT SATISFACTION SURVEY that will be completed by the consumer with the assistance of a Peer Support Specialist, if help is requested. The Peer Support Specialist will provide PATH staff and supervisors with a quarterly report on the Satisfaction Surveys. This feedback will be used to modify PATH service delivery as necessary, appropriate and responsible.

Consumer and family members participate and govern the LAC's, the KMA'S, and the WSAA. PATH specialist participate in monthly meetings amongst these groups, listen to needs of the population and advocate for needed services locally and state wide. These meetings provide a vehicle for consumers to express their concerns and issues and for staff to consider priorities of their budgets. The combined effort of staff and consumers appears to better drive the services that WMMHC provides, to include PATH services.

### **Western Montana Mental Health Center – BUTTE Budget FY 2008**

Outreach Worker .5 FTE	\$ 12,840
Clinical Supervisor 1hr/wk @\$50/hr	\$ 2,600
<b>TOTAL</b>	<b>\$ 15,440</b>
 Fringe Benefits	 \$ 3,500
 Travel	 \$ 2,538
 Other	 \$ 8,732
Supplies	
Housing assistance	
 <b>TOTAL</b>	 <b>\$ 30,210*</b>

**\*\$22,657.50 is federal funds and \$7,552.50 is general funds**

## **Western Montana Mental Health Center Bozeman FY 2008**

1. The Gallatin Mental Health Center, a member of Western Montana Mental Health Center, provides mental health services throughout Gallatin County (county population estimate in 2006 = 80,921) and into Eastern Madison County for persons who meet the criteria and are diagnosed seriously disabled mentally ill adults those identified as have a co-occurring illness. We have 4 service sights in Bozeman, Ennis, Three Forks and Belgrade. The service menu includes Psychiatric Medication Clinic, Outpatient Therapy, Adult Case Management, a five-bed Crisis Stabilization Facility, Emergency Services and mental health services to a growing Veteran population. PATH services have been provided for 5 years through Adult Case management Services.

GMHC currently provides mental health professional assessment and crisis services for Gallatin County and eastern Madison County. Additionally we contract with Bozeman Deaconess Hospital and all the smaller community hospital surrounding Gallatin County to provide assessment of emergency mental health cases presenting in the Emergency Departments. GMHC works closely with Montana State Hospital (MSH) to provide a step down bed for persons being discharged from MSH.

Contact: Scott Molloy  
Gallatin Mental Health Center  
300 N. Willson, Ste. 3005  
Bozeman, MT 59715  
(406) 522-7357  
Fax: (406) 522-8361  
Email: [smolloy@wmmhc.org](mailto:smolloy@wmmhc.org)

2. The Western Montana Mental Health Center of Bozeman will receive \$21,352.50 in federal PATH funds.

3.

a. The 2007 Montana Homeless Survey, which is a point in time survey that was taken on January 31, 2007, identified 74 homeless respondents/adults in Bozeman/District 9. Using the Corporation for Supportive House publication, "Estimating the Need: Projecting from Point-in-Time to Annual Estimates of the Number of Homeless People in a Community..." a conservative estimate of the number of homeless adults and children during the course of a year would be approximately 1800. The ratio of adults to children for the Point-in-Time survey was 64.7% adult. On an annual basis, this would represent 1165 homeless adults in Bozeman. The percentage of persons with serious mental illness and/or substance abuse who were homeless was 26.9% of the point-in-time survey. 26.9% of the estimated annual number of homeless adults would be 313. This would represent an estimate of the annual literal homeless population with mental illness and/or substance abuse for 2007.

Our estimate is that there are potentially 100 – 150 PATH eligible homeless persons who would access PATH services whether through the emergency, crisis stabilization or outpatient mental health centers. The data is based on Crisis Response Team reports, Hope House treatment plans, current Recovery Plans of clients and PATH data. This is a base figure that we anticipate going up due to the affordable housing crisis in Bozeman. The stress of lack of housing or risk of losing housing is being noted as a cause of mental health crisis with our most vulnerable of clients. This would represent 98% literal homelessness.

b. The PATH worker will be primarily responsible for linking adult clients with mental illness to local resources in order to provide stable and affordable housing. This person will also assist in linking these adults with mental health services in order to stabilize them mentally in order to lead a better quality of life. It is imperative that the mentally ill, homeless population be linked to mental health and substance abuse services in order to provide a foundation for a healthy life. The PATH worker would provide that necessary linkage in order to avoid future homelessness. This will be conducted through outreach in the community.

A large part of what the PATH worker will do will be seeking out the mentally ill, homeless population through local social service agencies and referrals from faith-based organizations such as Love, Inc. Most of our referrals in the past have come from this organization as they assist needy individuals with food, clothing, budgeting assistance, car repairs, home repairs, and transportation, to name a few. Since the Gallatin Mental Health Center has made targeted efforts to educate public agencies about the PATH program, we have seen a significant increase in numbers of mentally ill individuals seeking assistance.

GMHC maintains strong relationships with other local providers who work with homeless persons, providing shelter, health care, food and other emergency services. Important referral linkages include traditional mental health services, substance abuse treatment services. Additionally staff attends Adult Protective Services monthly meetings to review situations involving vulnerable mentally ill adults.

c. Other local agencies addressing the needs of homeless persons that current adult case Managers collaborate with includes:

- ◆ Human Development Resource Council
- ◆ Family Promise
- ◆ Gallatin Community Health Clinic
- ◆ Salvation Army
- ◆ Love, INC.
- ◆ Food Bank
- ◆ Soup Van Kitchen
- ◆ Vocational Rehabilitation/DPHHS – Bozeman Office
- ◆ Chamber of Commerce
- ◆ Faith Community
- ◆ Private Mental Health Providers
- ◆ Gallatin County Commissioners

These agencies become the team of committed community representatives who play host to homeless mentally ill and co-occurring persons. They act as the safety net for those in need of immediate intervention and linkages to long-range services that lead to independence and self-sufficiency.

Strengthening relationships with organizations serving veterans will assist in developing a greater referral base of homeless veterans with mental illness. Ongoing collaboration with Alcohol and Drugs Services of Gallatin County, Gallatin Community Health Clinic and through shared case management staffing will increase the visibility of the PATH program for specialized referrals. The Soup Kitchen Van and the Food Bank are two vital agencies in the service delivery to sustain some element of security of basic needs. We maintain active involvement with Human Resource Development Clinic, Law Enforcement, Jail Officers, the Montana State University Human Development Clinic, the Re-Entry Facility (half-way house for State of Montana Prison Inmates), the Department of Family and Children's Services, Love INC. (a Christian based non-profit who collaborates with other denominations to provide outreach of a social, financial and household nature) and Family Promise (a family based housing program that utilizes churches to house families).

d. Bozeman, one of the larger cities in Montana sitting in the County with the largest growth, is located on Interstate 90 and is easily reached by persons traveling East, West, North or South through Montana. The community is made up of a growing population of wealthy transplants from other parts of the country. The divide between those who have and those who are without is growing substantially. The mean average house price in Bozeman is now \$289,000 and affordable housing is being touted as 900 sq.ft. for \$220,000. Essentially there is no affordable housing outside of Section 8 housing with the Section 8 voucher waiting list being over a year long.

The community has an abundance of natural beauty and yet home town friendliness that has an invigorated drive to help persons with mental illness and the mental health center to be healthy and thriving. The social structure of the community is changing with more development of franchise businesses with an intact downtown shopping district. Montana State University continues to enjoy a booming enrollment that also competes for the limited affordable housing. The community continues to make strides toward welcoming all and at the same time is struggling to develop an infrastructure that supports all levels of income and mental wellbeing.

PATH Workers have arranged mutual agreements with the Community Health Center to provide health care to homeless individuals. A gap exists to pay for ongoing medical care beyond initial screen and ongoing medications. The PATH Workers have received a scholarship from various pharmaceutical representatives to assist in paying for medications on a limited basis. The primary gap is the difficulty homeless mentally ill persons have in accessing ongoing financial support after the first month of initial eligibility for PATH and the several other forms of temporary assistance have run out. The PATH worker can usually rally services for initial stabilization period. There have been historical delays accessing and enrollment into traditional mental health services. There are many fears based on past experiences, sometimes disorganization and confusion that makes follow through with appointments difficult. Additionally, there are waiting lists for services and

persons must be assessed and receive an intake into the system in order to receive services. PATH workers meet people in the natural environment and through engagement are able to build a relationship that encourages trust and facilitates the next step, the formal linkage/enrollment.

e. The PATH funded Case Manager has access to those who attended and received ongoing in-service training on Minkoff's Co-Occurring mental illness and substance abuse training. PATH clients are assessed at clinical intake for dual disorders. Treatment groups are offered at the Center for both disorders. The PATH Case Manager works closely with the local state funded chemical dependency provider Alcohol and Drug Services of Gallatin County. Drug and Alcohol Services serve to coordinate chemical dependency treatment as part of the recovery plan for the PATH client. Co-occurring mental illness and substance use disorders are also met by referring to community resources such as AA/NA groups and Montana Chemical Dependency Center in Butte.

f. Our PATH specialist will coordinate with local landlords to assist homeless individuals in need. Without the availability of PATH case management assistance most of the homeless consumers would find insurmountable barriers in obtaining housing. Housing services provided include one-time payment of utilities and/or deposits, one-time security deposits, and one-time payment of rent/utility to prevent eviction. On occasion, the program will pay damage repair caused by a homeless person for whom we have provided temporary shelter. Housing services are also provided to coordinate and advocate with housing programs (shelters and SROs), landlords, and community coalitions. The Case Manager visits daily and coordinates referrals, income assistance, health care, and is available for other referrals.

4. GMHC is an active participant in the local housing task force (Continuum of Care for the Homeless) and maintains strong relationships with other local providers who work with homeless persons, providing shelter, health care, food and other emergency services. This committee assesses needs, develops resources and responds to those needs in the community. This planning process is involved in the Continuum of Care and Consolidated Plan at the State level. The PATH worker will participate in City Commission meetings that have a focus on housing to insure a representation for the PATH consumer.
5. The service needs of the target population are twofold. One is the emergent nature of the populations need for a safe short-term sanctuary. Two is the need for development of access to affordable housing in Gallatin County. The clients often emerge with multiple needs to include mental health and co-occurring services with the expectation that we help them to establish an ability to participate in the development of their plan for permanent housing. Individuals who meet the criteria for PATH eligible services in our experience do not recognize the boundaries of "qualifying" for services but rather present with emergent and urgent needs. The PATH worker is the key to establishing safety, assessing the needs, assessing the client's ability to participate in a plan and brokering the services available in the community to make the plan a success.

The Lead Adult Case Manager of GMHC will be identified as the PATH Coordinator. This person will assume a lead role in the collaboration with other agencies and determining staff assignments. Outreach will occur on a daily basis, by either the Coordinator, or the PATH Outreach Worker to identify prospective referrals and begin to engage potential consumers. Daily outreach will occur to meal sites and shelters and staff will familiarize themselves with the environments that prospective PATH consumers are comfortable in. Education of referring agencies will assist in the referral of homeless persons who are SDMI. A clinical supervisor will meet with these employees weekly to discuss challenging situations or cases that might pose risk to either the consumer or the staff. No other entities will provide services with PATH funds, other than GMHC.

The grant is for a 0.5 FTE PATH case manager who will be a part of an experienced Adult Case Management team. Recruitment has already begun with both professional case managers and consumers in recovery showing a good deal of interest. The adult case management team is in discussion as to how to accommodate the diversity of interest. GMHC has been actively consulting with the Missoula and Butte offices of WMMHC who have been more actively engaged in PATH services with much more volume than GMHC.

6. Consumers and family members participate and govern the Local Mental Health Advisory Council and are members of the Central Service Area Authority Congress. We have representation at both of those advocacy groups that represent participation in NAMI and MMHA. PATH Case Managers are members and active participants in this monthly group advocating for services to the county and the state. PATH identified clients are included in the annual satisfaction survey conducted by the Center. Peer support groups are held weekly at the Center and PATH clients are urged to participate. WRAP has a presence in our community with one of our GMHC staff members being a trainer and a consumer being a trainer. We have started the development of an active group of individuals who are practicing WRAP and using their empowerment skills to help other peers.

# WESTERN MONTANA MENTAL HEALTH - BOZEMAN BUDGET FY 2008

## **I. Personnel**

### **A. Salaries**

Program coordinator/outreach .05 FTE	\$13,840
\$27,680 annual salary	
Clinical Supervisor 1 hours per week @ \$50.00/hour	\$5,200

### **B. Fringe benefits/Health Insurance**

.5 FTE benefits	\$3,500
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<b>Sub-total</b>	<b>\$22,540</b>
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## **II. Travel** (in-state only related to the project)

100 miles/week @ .485 X 48 weeks	\$2328
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<b>Sub-total</b>	<b>\$2328</b>
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## **III. Other**

Administrative overhead 9.5%	\$2362
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Housing asst. revolving loan fund	\$1240
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<b>Sub-total</b>	<b>\$3602</b>
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<b>Totals</b>	<b>\$28,470</b>
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**\$21,352.50 is federal funds and \$7,117.50 is general funds**

## **Western Montana Mental Health Center Kalispell FY 2008**

1. WMMHC provides mental health services to Western Montana. Flathead County Adult Mental Health (FCAMH) provides mental health services to seriously disabled mentally ill adults (SDMI) in Flathead County (population 70,000). These services include Day Treatment, Psychiatric Medication Clinic, Outpatient Therapy and Case Management Services, Crisis stabilization Services, Emergency Services, PACT, residential services, and mental health services to veterans. PATH services have been provided for 10 years through Adult Case Management Services. PATH outreaches those in need and after first contact if client is willing, will engage in services at WMMHC beginning with an Intake Assessment followed by an appointment with our Psychiatrist for further assessment and determination as to what other services, e.g. Case Management, Day Treatment, Individual Therapy, Co-occurring group(s) would be appropriate. There is need for transitional housing related to the limited number of shelter beds in the Flathead area. This could include renting more than one room at the Homeless Shelter to provide housing while working on entitlements and other services.

Flathead County Adult Mental Health currently provides mental health professional assessment and crisis services for Flathead County. Additionally we contract with Pathways/KRMC and North Valley Hospital to provide assessment of emergency mental health cases presenting in the Emergency Room. FCAMH works closely with Montana State Hospital. FCAMH has provided PATH outreach in the community through contract with the State of Montana for 10 years.

Contact: Shirley Howell  
Western Montana Mental Health Center  
410 Windward Way  
Kalispell, MT 59901  
406-751-8370  
406-257-1353  
[showell@wmmhc.org](mailto:showell@wmmhc.org)

2. The Western Montana Mental Health Center of Kalispell will receive \$22,657.50 in federal PATH funds.
3.
  - a. It is estimated that there are potentially 100-150 PATH eligible homeless persons who will use the PATH service. This is based on past figures regarding this service utilization and projects an increase if this proposal is accepted due to a request for additional staffing. This would represent 98% literal homelessness. Those at risk for homelessness and potentially eligible could be much higher.

In 2006, the demand for homeless services at the Samaritan House increased by 28% and 395 people were turned away due to full occupancy at the Shelter. In 2007 Montana Homeless Survey, which is a point in time survey taken January 31, 2007, identified 435 homeless adults and children living in Kalispell, MT. Using the Corporation for Supportive House application, "Estimating the Need: Projecting from Point-in-time to Annual Estimates of the Number of Homeless People in a Community..." a conservative estimate of the number of homeless adults and children during the course of a year would be 3700. The ratio of adults to children for the PIT Survey was 64.7%. On an annual basis, this would represent 2393 homeless adults in Kalispell. The percentage of persons with serious mental illness and/or substance abuse who were homeless in the Flathead was 26% of

the PIT Survey. 26.9% of the estimated annual number of homeless adults would be 644. This would represent an estimate of the annual literal homeless population with mental illness or substance abuse for 2007.

b. Outreach will include first contact to determine if they are eligible for services. The process then continues through the steps to connect with services at the Mental Health Center and the community. The population is identified through referrals from APS, Samaritan House, social services, police department and the mental health professional or a visual of someone who appears in need. Individuals are approached and told what services could be provided and then ascertaining if they want services. Outreach is ongoing and as needed. This includes educating other agencies on what PATH is and does. It also means educating agencies as to the financial limits of PATH program.

c. The local system also includes one Homeless Shelter, Samaritan House, transitional housing through the Rose Briar Inn and Salvation Army, a local food bank and one meal site, Salvation Army. Community churches provide an evening meal nightly. Touch of Grace Clinic in Kalispell and Shepherd's Hand in Whitefish provide free health clinics. Both are open one night per week and provide a free health screening and one-time medication assistance. PATH workers have received a scholarship from various pharmaceutical representatives to assist in paying for medications for the homeless persons on a limited basis.

Daily PATH-funded Case Manager outreaches and visits the Homeless Shelters and single room occupancy motels. The Samaritan House has made available an office space for the Case Manager to meet with homeless folks. Monthly outreach and public announcement of the service is made at the APS Team, United Way Social Service Agency meeting, and Mental Health Advisory Council meetings. At these community meetings, social service agencies and advocacy groups meet to educate and coordinate publicly funded basic needs services for the County. Quarterly PATH Case Manager outreaches the local VA Clinic, Salvation Army Free Health Clinic, and attends the Continuum of Care Coalition for Homeless. On an as needed basis, PATH services and coordination for homeless individuals is made available through the on-call mental health professionals to local Police Departments, Sheriff's Office and Detention Center.

d. Kalispell can have brutal winters. If someone is homeless and doesn't qualify for the local Homeless Shelter, (there is a 90 day lifetime limit), we provide blankets and food and a room at one of the local motels like the Blue & White or Motel 6 especially when it's very cold. The Blue & White has been known to extend a person's stay one or two days.

Many of our homeless population only have 30 day stays at the Samaritan House. This can be problematic if they do not have items needed e.g. birth certificates, IDs, Social Security cards to get the programs started. Also if they are unable to work, getting entitlements can take a significant amount of time and of course are not guaranteed to happen. If they are able to work and get a job, it is almost impossible to pay rent and a deposit on minimum wage employment.

Also, many of our homeless folks struggle with personal relationships and have difficulty being around others. This inevitably results in losing their housing due to fighting or not following the rules. When this happens it is almost impossible to find immediate housing and the individual goes back to the streets which makes it difficult to find them again to provide services that are desperately needed.

e. Flathead County Adult Mental Health Center staff are trained to work with person with co-occurring disorders and consumers with co-occurring disorders will be served within this system.

For consumers with primary substance abuse issues, treatment referral options are in place both for detox and outpatient treatment. There will be ongoing coordination and linkage with substance abuse treatment providers, including Native American services provision. Additionally peer support groups such as AA, NA, GA and dual diagnosis groups will be utilized for referral and support.

f. Our PATH worker coordinates with local landlords and the Northwest HRDC to identify housing that would include: apartments, efficiency apartments, shared housing with peers, assisted living and transitional housing opportunities. It primarily involves networking, assisting with security deposits, and completing applications. Staff has also been able to utilize the Shelter Plus Care Voucher in our area. The program capacity is an “as needed” program.

4. FCAMH is an active participant in the Flathead County Continuum of Care for the Homeless and maintains strong relationships with other local providers who work with homeless persons, providing shelter, health care, food and other emergency services. This committee assesses needs, develops resources and responds to those needs in the community. This planning process is involved in the Continuum of Care and Consolidated Plan.
5. An example from our files include: A 40 year old female who had been homeless for five years. This person would walk almost all night and sleep and panhandle for money during the day. This person continues to refuse services from our Center but because she was a Veteran, we were able to first get her into the homeless Shelter in a room we provided. While there we were able to get food stamps and connect with Northwest Human Resources. She now has an apartment through the Shelter Plus Care Voucher. She also obtained her birth certificate, ID, connected with Job Service, and VA Medical Services. She is eligible for SSI but continues to refuse pursuing this. This individual is extremely paranoid and it took Ms. St. Peter and least 1 year of frequent outreach to secure safe housing for this individual. Building rapport and trust are the key ingredients in successful outreach. De-escalation skills and crisis management are crucial to engaging mentally ill homeless persons. The ability to meet the person where they are at and knowing when to proceed and/or back off are essential.

The Kalispell area has seen a rise in the homeless population. Many of the homeless are unemployable which translates into no funding for rent for housing. Many are transient and “passing through” and need short-term assistance with food, clothing and water. Other who remain in the area need mental health services, medications, housing etc. Some are unable to complete applications for services due to poor reading and writing skills. This service is provided when needed. Then there are others who may have funding through SSI or SSDI but housing can remain a problem related to poor social skills, criminal records or poor references. We then may investigate purchasing a small trailer or motor home in which to live.

Our main population is mentally ill homeless. Some ways we have contact is through our local Homeless Shelter, Samaritan House, police department, and Adult Protective Services. We also are contacted through Pathways Treatment Center and local nursing homes.

There will be two primary staff associated with the PATH program. One is a Master's degreed Clinical Supervisor, who has 15 + years experience with Case Management and 3 years experience with PATH. The previous PATH case manager resigned due to medical reasons. The program will be replacing the case manager as soon as possible.

6. PATH staff in the course of doing their work solicits comments from the client base as well as families regarding the services provided. A PATH RECIPIENT SATISFACTION SURVEY was

recently designed by Western Montana Mental Health Center that will be completed by the consumer with the assistance of a Peer Support Specialist, if help is requested. The Peer Support Specialist will provide PATH staff and supervisors with a quarterly report on the Satisfaction Surveys. This feedback will be used to modify PATH service delivery as necessary, appropriate and responsible.

**Western Montana Mental Health Center – Kalispell  
Budget for FY 2008**

Outreach Worker .5 FTE	\$ 12,840
Clinical Supervisor 1hr/wk @\$50/hr	\$ 2,600
<b>TOTAL</b>	<b>\$ 15,440</b>
 Fringe Benefits	 \$ 3,500
 Travel	 \$ 2,538
 Other	 \$ 8,732
Supplies	
Housing assistance	
 <b>TOTAL</b>	 <b>\$ 30,210*</b>

**\*\$22,657.50 is federal funds and \$7,552.50 is general funds**

## **CENTER FOR MENTAL HEALTH**

### **Great Falls – FY 2008**

1. Center for Mental Health has been providing successful services for the targeted population for 10 years. Our staff is well trained and capable of meeting the requirements of this grant. Our project officer has been the director of community services since 1975, directing the PATH program since the inception in 1997. Serving an average of 300 persons per year in that program. This year we were awarded 4 shelter plus care vouchers by the state to make available to the targeted population. Our relationship with Great Falls Housing Authority awards us the privilege of accessing housing for the homeless with guarantee of PATH supervision.

Center for Mental Health's mission is to provide the highest quality therapeutic mental health services to the individuals it serves. CMH has provided services to the community for 33 years, 10 years working the PATH program. The PATH workers assist targeted individuals to gain necessary access care, meet the needs which provide stability and transition out of homelessness.

Our FTE worker has been in case management for 10 years, 6 of those have been as the PATH worker. One.5 FTE has been doing case management for 11 years, 3 years of PATH work. The other .5 FTE has been a case manager for 11 years, has currently been working with PATH for 6 months.

Contact: Gwen Valley  
Center for Mental Health  
915 1<sup>st</sup> Avenue South  
Great Falls, MT 59401  
406-761-2196  
Fax: 406-761-2107  
[gwenv@center4mh.org](mailto:gwenv@center4mh.org)

2. The Center for Mental Health will receive \$22,657.50 in federal PATH funds.
3.
  - a. 100 homeless individuals on average are in our community at any given time. Our PATH reports and the PIT homeless survey was our source of data.

Estimated 500 individuals, of these people about 33% are literally homeless, 67% are at risk. Our PATH reports and the PIT homeless survey are our main source of data.

We estimate that there are 500 persons in need of PATH services during the fiscal year. We intend to service at least 380 of these individuals. Our PATH reports and the PIT homeless survey were used for estimation. We are already seeing increases in our communities.

b. CMH will agree to provide targeted population who are homeless and seriously mentally ill the opportunity to actively participate in the PATH program. Individuals will not be excluded based on co-occurring substance abuse problems. PATH workers will locate and identify individuals are in the targeted population, working to engage them in services and programs that may offer an opportunity or a choice to transition out of homeless. PATH will provide linkage and referral to targeted individuals until transferred to Medicaid, mental health funded services, case management and other supported services. Referral to Medicaid or MHSP or another provider will be made as soon as possible when the individual is willing and capable of engagement. The PATH worker will continue to engage targeted individuals as deemed necessary to engage the individual's transition from homelessness. Referral and linkage services initiating services for entitlement, housing, medical services, etc. as well as providing or assuring the availability of representative payee services when necessary. Each designated PATH worker will be assigned several ethnic, faith-based, VA service organization and agencies in the community. They will visit, offer education and take referrals for potential individuals. Outreach contacts will include, Native American locations (reservations, Indian Health Centers, etc.), bridges, homeless coordinators for schools, camps, bus depots, jails, shelters, police departments, and any other locations that are appropriate.

Engagement process would include contacting individuals who are homeless, have a mental illness, substance abuse, co-occurring problems and those who are at risk by encouraging them to participate and obtain the necessary opportunities that may assist them in transitioning out of homelessness. This may take repeated contacts over a long duration of time. The staff currently has availability and familiarity with all agencies along with building a trust with the individuals. This trust has been built on frequent contacts, offering basic needs such as food, clothing, sleeping bags, etc. Respecting individuals along with offering assistance and accompaniments to necessary appointments and resources.

Deb Halvorson, BS will be working 20 hrs per week for PATH and Pauline LittleOwl, BA will be .25 FTE working 10 hrs per week for PATH.

c. Primary health care providers utilized by PATH program staff include Benefis Hospital, City-County Health Dept., Great Falls Clinic, and Center medical staff. Substances abuse providers utilized are Benefis Hospital, Great Falls Rescue Mission, Gateway Recovery, Discipleship CD program and the Montana Chemical Dependency Center in Butte. Others include Great Falls Food Bank, Set Free Ministries, Salvation Army, Saint Vincent de Paul, Opportunities Inc., various faith based organizations and community groups and clubs. Our staff has a very good working relationship with these programs and often together come up with creative solutions.

Housing providers utilized are Great Falls Housing Authority, Rescue Mission, Opportunities Inc., Agape Investment Center (youth), and individual landlords in the city. (this will be accessed by accompanying the individuals to the specific

placement and assist in filling out necessary paperwork to obtain a place to live.) Our PATH workers guarantee supervision of individuals once placed in housing. We have daily contacts with the local Rescue Mission. Staff has excellent rapport with various agencies such as the jail, City County Health Department, Indian Health Center, Adult Protective Services, and other agencies in town.

d. Immediacy of need for the individuals is to prevent them from being jailed, hospitalized, death due to extreme exposure, or undiagnosed or untreated medical or psychiatric conditions. Other issues are evictions due to the lack of resources, CD issues, and lack of supervision in their living areas. The needs were determined by self referral, family members, jails, agencies, public observations and referrals. The homeless count helps determine the population in the area. Sixty percent of the targeted population in our area is untreated for mental health and co-occurring issues. They have become or are at risk of becoming homeless. Five percent of the population are mentally ill veterans; thirty-five percent of homeless population have mental health and medical issues. Of the clients we currently serve in our PATH program, twenty percent are Native American, nineteen percent African American, less than one percent Hispanic, 75% white, 3% unknown. Estimated age of individuals in our area 60% are 35-49 years old, twenty percent are 50-64 years of age, eighteen percent are 18-34 years of age and two percent are 65-74 years of age. Of these individuals sixty-five percent are reported to be suffering from schizophrenia, thirty-five percent are other SDMI disorders.

e. staff are trained to work with person with co-occurring disorders and consumers with co-occurring disorders will be served within this system. For consumers with primary substance abuse issues, treatment referral options are in place both for detox and outpatient treatment. There will be ongoing coordination and linkage with substance abuse treatment providers, including Native American services provision. Additionally peer support groups such as AA, NA, GA and dual diagnosis groups will be utilized for referral and support.

f. Housing providers utilized are Great Falls Housing Authority, Rescue Mission, Opportunities Inc., Agape Investment Center (youth), and individual landlords in the city. (This will be accessed by accompanying the individuals to the specific placement and assist in filling out necessary paperwork to obtain a place to live.) Our PATH workers guarantee supervision of individuals once placed in housing. CMH has been assigned Shelter Plus Care vouchers for housing the homeless. Staff is trained on the HMIS and will implement this program. FTE PATH worker spends every Thursday morning at the Housing Authority.

4. Staff attends Continuum of Care meetings on a monthly basis. Propose possible housing projects. Consumers are also invited to attend these meetings. Center for Mental Health PATH program participates in local Continuum of Care, and also proposed housing for the homeless to be built in collaboration with the Housing Authority. We participate quarterly and on an as needed basis with State PATH director and other workers.

5. The targeted population in our community is in need of safe and affordable housing, identification (such as birth certificates, picture Id's), they need benefits which include Social Security, food stamps, etc. reinstated. There is a high need for medical, CD, mental evaluation and treatment, advocacy and resource referral along with a need for medications. The highest priority for this population is to have their basic needs met and to be viewed as individuals who are worthy and treated with respect. Some gaps include: lack of safe affordable housing, no rental history, long waiting periods for Social Security benefits, timeframe for financial benefits to be released, and long waiting lists to see a medical doctor or a psychiatrist. The PATH workers fill the gaps by offering resources to provide temporary housing. Assist with obtaining birth certificates and Id's, advocating for permanent housing options along with working with the Housing Authority, Opportunities Inc. The use of Shelter Plus Care vouchers for permanent housing. Providing assistance getting Social Security applications filled out and reinstatement using the SOAR techniques. Advocate for medical, CD and mental health treatment through community organizations.

Our FTE worker has been in case management for 10 years, 6 of those have been as the PATH worker. One.5 FTE has been doing case management for 11 years, 3 years of PATH work. Each designated PATH worker will be assigned several ethnic, faith-based, VA service organization and agencies in the community. They will visit, offer education and take referrals for potential individuals. Outreach contacts will include, Native American locations (reservations, Indian Health Centers, etc.), bridges, homeless coordinators for schools, camps, bus depots, jails, shelters, police departments, and any other locations that are appropriate.

The Center provides orientation for PATH staff, as well as all other staff, which addresses the needs of diverse individuals and demonstrates skills, which are sensitive to these needs. The Center cosponsors an annual Native American conference coordinated by For the Children, with twenty training slots for Center staff each year.

6. The consumers' role in developing and implementing this project will be taking an active part in their own support. The PEER program support is a valuable opinion. They have the right to choose unless mandated otherwise by a court system, staying within the program, the right to have fair representation, treated as a valuable resource. We have a very active PEER program within the center and they work with homeless people in crisis.

## Center for Mental Health Budget for FY 2008

### 1. Personnel

#### A. Salaries

Program Coordinator/Outreach worker: .75 FTE	\$20,581.00
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#### B. Fringe Benefits

FICA	\$ 1,574.00
Health Insurance, Retirement, Workers Comp	
Unemployment Insurance,	\$ 1,440.00

<b>Sub-total (Salaries &amp; Fringes)</b>	<b>\$23,595.00</b>
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C. Travel	<u>\$ 504.00</u>
(20 miles per week per FTE @ .485 per mile)	

Sub-total (Travel)	\$ 504.00
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### 2. **Other**

Non-Medicaid/Non-MHSP cop-pays	\$ 300.00
Access issues (birth certificates, Id's, etc.)	\$ 200.00
Transportation for clients	\$ 800.00
Utilities	\$ 0.00
Communication	\$ 0.00
Supplies	\$ 500.00
Staff development	\$ 200.00
Housing asst. revolving loan fund	\$ 2,000.00
Cell phones	<u>\$ 250.00</u>

Sub-total (Other)	\$ 4,250.00
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<b>Sub-total (Personnel, Travel &amp; Other)</b>	<b>\$ 28,349.00</b>
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3. <b>In-Direct expenses</b>	\$ 1,861.00
(Payroll, Accounts Payable, Record Keeping) (10%)	

<b>GRAND TOTAL OF CONTRACT</b>	<b>\$ 30,210.00</b>
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